NORTH DAKOTA MEDICAID PROVIDER APPEAL FORM

ND DEPARTMENT OF HUMAN SERVICES
LEGAL SERVICES
SFN 168 (09/2005)

Clear Fields

Provider Name	Provider Number		
Provider Address	City	State	Zip Code
Provider Contact Person	Telephone Number		
Medicaid Recipient Name	Medicaid Recipient Number		
Date(s) of Service	Date of Remittance Advice (Enclose Copy Also)		

Reason for appealing denial or reduction in level of service payment from the North Dakota Medicaid program (additional pages may be submitted if necessary):

Statement of remedy sought including a computation and the dollar amount of your claim for each disputed item (additional pages may be submitted if necessary):

In order to appeal a denial or reduction of payment, this completed form must be submitted within 30 days of the date of the Department's remittance advice.
Submit to:

North Dakota Department of Human Services
Appeals Supervisor
State Capitol - Judicial Wing
600 East Boulevard Ave.
Bismarck ND 58505

All documents, written statements, exhibits, and other written information that support the appeal must be submitted to the Department within 30 days of your request for appeal. A copy of this completed form must be attached to any additional information you submit to the Department.